Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of:	)	
	)	
Rural Health Care Support Mechanism	)	WC Docket No. 02-60

COMMENTS OF BROADBAND PRINCIPALS

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(Paragraph numbering scheme corresponds to the related paragraphs in the NPRM)

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The Broadband Principals respectfully submit their comments in response to the above-captioned Notice of Proposed Rulemaking ("NPRM"). This proceeding concerns the future course of this nation's rural health care industry. If this program is smartly designed the Commission can reshape the nation's rural health care infrastructure, and thus play a large role in the economies and well being of rural America. Broadband Principals are consultants Amy Stern and David Kelly, each with over thirty years of experience in the telecommunications industry. Over the past year Broadband Principals has spoken to numerous rural health care providers about their broadband and telecommunications needs and interests. It is with this background that the following comments are respectfully submitted.

INTRODUCTION and SUMMARY

In its NPRM, the Commission seeks comments on a new approach to making broadband affordable and more accessible in medically underserved rural communities. It seeks to provide patients in rural areas access to the state-of-the-art diagnostic tools that are typically available only in the largest medical centers. These are laudable goals and we applaud the COMMISSION for working on this opportunity to bring better, more affordable health care to all Americans. Broadband Principals' comments and suggestions generally have a few key themes. First, the proposed infrastructure program is a step in the right direction; however, in order to encourage

more infrastructure builds, it should be designed, much like the Department of Agriculture's Rural Utilities Services' Broadband Initiatives Program (BIP), to allow carriers in the industry to own and control broadband facilities, rather than forcing this responsibility on the health care providers. Likewise, we support proposals that make it easier for consortiums and administrators to manage telemedicine networks and services on behalf of health care providers. Third, we support simplifying the broadband and telecommunications services programs to make them easier for health care providers to access and use. Finally, the Commission should increase the support levels in a manner that encourages the utilization of broadband technology by even the smallest rural healthcare providers by recognizing that large urban hospitals often receive significant discounts on their telecommunications off the "published" prices.

III. Health Infrastructure Program

A. Program Process

Initial Application Phase: The NPRM suggests that applications would be accepted only during the first quarter of each funding year (July 1 to September 30). We regard this as an unnecessary limitation. Many would-be applicants and health care providers have different time frames when they (a) become aware of the program, (b) are ready to make changes due to timelines and expiration of their existing contracts (c) can obtain commitments and availability of matching funds, and (d) have availability of other internal resources needed to change their infrastructure. Given all of these factors, and given that in past years the program has been underutilized, it seems arbitrary and unnecessary to limit the application period to one quarter of the year. Applications should be allowed throughout the year as long as funding is still available. The Universal Service

Administrative Company (USAC) should make a public announcement when funding for the year has been used up.

With respect to Letters of Agency from eligible health care providers, it should be clear that these are not binding on the health care providers at the initial stage of the process. A health care provider should not be bound to a single applicant until it is certain that the USF funds will be made available to the specific project, and that the infrastructure provider will be able to offer the services for the prices and time frames quoted.

Build-out period: The build-out period of five years is too long. The purpose of the program is to make urgently needed medical care more accessible to rural communities. Given this goal, build-outs should be completed in three years rather than five years. A three year build-out would be consistent with the requirements of the ARRA in its BroadbandUSA BIP infrastructure program (**Federal Register** / Vol. 75, No. 14 / Friday, January 22, 2010 / Notices, p. 3826), for which there was no shortage of applicants. Since there were large numbers of applicants for that program, it seems reasonable that carriers are confident they can do build-outs in a three year time frame

B. Provisions Applicable to Initial Application for Funding

Proposal period: The six month time frame for demonstrating that there were no bids from qualified vendors is sufficient. Cycle times for RFPs generally range from 30 to 90 days. Therefore, a six month period is long enough to allow a health care provider time to issue a RFP and receive responses, or, upon not receiving any credible responses, the provider could then modify and reissue the RFP for a second round. In fact, if the

COMMISSION considers extending the time frame to greater than six months, it should consider making an option of (a) the six month timeframe, or (b) the unsuccessful solicitation of at least two rounds of RFPs to at least eight carriers, whichever occurs first. This approach will balance a credible demonstration of the rural healthcare provider's attempt to obtain competitive bids with the societal need for speed that is the purpose of the project.

Consortium applications: We generally agree that any discounts, funding, or program benefits should be passed through from the consortium to the eligible health care providers. However, it should be clarified that consortium or other administrative bodies should be allowed to subtract reasonable fees to recover their costs of management and administration prior to passing through such benefits. The health care providers that consortiums serve are health care providers, and not broadband experts. As such, the consortium or administrator will bear a large burden of managing these projects. If they have their hands tied with respect to recovery of their costs, they will not step up to the plate to perform these functions, thus leaving smaller clinics and hospitals to fend for themselves. Once this happens, many small hospitals and clinics will choose to opt out of the program rather than incur the risks and costs of managing the infrastructure build on their own. Administrative and Management Fees: Administrative and management fees that should be allowed, for either a consortium manager or for a health care provider include: costs of administration of maintenance and repairs, costs of administering service quality measurement, monitoring, and contract compliance, costs of soliciting, negotiating and creating RFPs and supporting documentation, costs related to finding and selecting vendors to provide the allowed services, costs of reviewing vendor bills and

compliance, administrative costs of obtaining matching funds, loans, and grants to be used in connection with an approved infrastructure program, costs of executing any emergency response and disaster recovery requirements, administrative costs of working with vendors and health care providers to resolve network problems and procure compatible equipment and overall project management costs for the project. We advocate allowing a baseline fixed cost for administration expenses that is sufficient to cover even the small health care providers' needs. For larger projects, given that the capital costs of these projects will vary significantly, a cap on administration costs could be based upon a percentage of the project's size.

Project prioritization, caps on amount funded per project, and caps on number of projects per year: There should not be a cap on the number of projects per year or the cost of individual projects. The rural health care sector is not "one size fits all". A few small clinics grouped together in Alaska will have very different needs than a hospital in Maine, etc. In any given year, applications may come in for varied infrastructure requirements. It is wrong to pre-judge which projects are more deserving than other based simply on a cap, without regard to how many people the project will reach and help, and the efficiency of the project design. If there are requests for more money than is available, funds could be allocated based upon patients reached per dollar spent, perhaps with weightings for more critical patients or longer distances from acute care hospitals. The FCC should work with medical industry members and associations in a task force approach to come up with a formula for prioritization that is not administratively onerous for even the smallest of clinics. It should set a deadline for concluding this process.

Billing and operational expenses: We disagree that these types of expenses, when related to the broadband infrastructure, should be considered ineligible. It is unrealistic to surmise that a network can be run without some operating expenses. Operating systems and infrastructure must be tested and maintained if they are to continue to work properly. Personnel need to work on routine procedures to ensure network reliability, repairs when a network component fail, and on upgrades when new technologies and improved equipment becomes available. Without allowing for recovery of these costs, it is only a matter of time before the rural health care providers this program seeks to benefit will fall behind the rest of the nation's health care once again, and be in the same position as they are in currently. As far as allowing billing costs to be recovered, it is realistic to assume that most clinics and rural hospitals, except for possibly the largest ones, will share infrastructure as part of a larger consortium, since they will not have enough resources to manage a network themselves. As such, the consortium will need a vehicle for recovering expenses to the extent that the USF will not fund100% of their broadband related expenses. Certainly if the broadband infrastructure is to become self-sustaining, which is a requirement, then it must be allowed to recover costs. Billing the health care providers or others who use the network is a logical way to recover those costs. Therefore, billing becomes as essential to the operation as any other component, like laying cables or trenching or power, if the system is to continue working properly and be self-sustaining. Billing cost recovery should be allowed.

C. Provisions Applicable After Initial Application

Fifteen Percent Contribution Requirement: The funding contribution requirement will be difficult for small not-for-profit hospitals and clinics to meet. This would require an extraordinary one-time fund-raising effort. Many small clinics either do not have personnel available to manage such a fund-raising effort, or have personnel whose expertise lies more in the medical fundraising area than in broadband fundraising. What's more, the timing of a not-for-profit fundraising cycle is elongated, generally taking at least six months to as much as two years from start to finish. It would be extremely difficult to coordinate that type of cycle timing with the rigid timeframes proposed by the F.C.C. for entry into the USF program.

On the other hand, as discussed below, if the F.C.C. were to leave the ownership of the infrastructure builds with teleco/cable carriers rather than with the health care providers, it would be easier to get matching contribution commitments. Under the BTOP and BIP programs pursuant to the ARRA, 20% was not an impediment to attracting many qualified applicants. Based on that experience, it seems that if teleco/cable carriers were allowed to own the infrastructure, the matching fund requirement could be raised to 20% rather than 15%, which would free up additional money so that additional projects may be funded.

In either case, whether the teleco/cable carriers or the health care providers have ownership and matching obligations, in order to ease the ability to obtain capital, many of the restrictions the COMMISSION proposes in this NPRM should be lifted. BIP and BTOP did not have as many restrictions. Restrictions on funding from sources such as in-kind or implied contributions; local exchange carrier (LEC) or other telecom carrier, utility, contractor, or other service provider; and for-profit participants should be

removed. Allowing these parties to participate as contributors in this USF program will relieve the problems of finding matching contribution sources. This program should mirror the BIP and BTOP programs where there was no shortage of applicants, despite the 20% match requirements. (There were rules on how to structure for-profit parties' participation in the BIP and BTOP, but those rules did not preclude participation by those parties, and many did actively participate.)

We generally agree with the Commission's proposal that there should not be restrictions to any particular technology type. We generally agree with the Commission's proposals that project descriptions should identify all network participants, speeds and services, that project participants should identify how their networks will be used to advance health IT and health care delivery. Facilities Ownership, IRU, or Capital Lease Requirements: The Commission's approach on ownership has fundamental flaws that could doom the program to the under utilization that the Commission is seeking to avoid. The target beneficiaries for this program are generally small to mid-sized clinics and hospitals. They have core competencies in the business of providing health care, and not in owning and managing networks. This is not their business, not their strength, and they do not have resources to care for this. On the other hand, it is the business and core strength of carriers to build and operate networks. Carriers want to own and operate networks on an ongoing basis; this is how they remain viable and sustain their businesses. However, very few of them want to be in the business of constructing networks, only to turn the network's ownership over to another owner after the construction is completed. They are much more motivated to build when they can forecast a steady stream of future revenues for 15 or 20 years after the build is completed. Otherwise, they are relegated to being

"one-off" construction companies, which is not the profitable part of the business for most of them. Without allowing carriers to continue ownership of networks they build, there will be few of them interested in bidding to do these infrastructure build-outs. Likewise, there will be less health care providers willing to take the risk of being burdened with owning and managing networks they know nothing about. (In addition to the obvious day-to-day ownership and management issues, the health care providers owning networks for the first time could also be subjected to additional tax burdens, additional government regulations, new and unfamiliar interconnection fees, and they would not experience the economies of scale that even smaller carriers have with respect to network management. This places the health care providers in an undesirable position when considering ownership. There will be many more program applicants if, as with the BIP program, Telcos and carriers are allowed to own the networks.

Depreciation of network components and disposition of assets: After the full economic useful life of the asset has expired, sale of assets should be allowed. To not allow this would be an unnecessary restriction that would deter investment in these networks.

Shared Use: We agree with the proposal that capacity not utilized by the not-for-profit or governmental rural health care provider should be shared with others. It is particularly important in rural areas, where densities are low, to pack as many users as possible onto a relatively fixed cost platform in order to drive costs per user down and make broadband more affordable and contribute to the economic development of rural America. For this reason, there should not be any restrictions on *who* may use the spare capacity of a network, and thus for-profit health care providers, other for-profits, and other not-for profits should all be allowed to use these networks once the fixed costs are sunk and the

network is built. However, there should be rules regarding of the participation of these entities as follows:

(1)Revenues from these other entities should be used towards defraying the costs of the network. If the COMMISSION uses its model where the not-for-profit health care provider owns the network and there are revenues from outside users, those revenues should be used to defray network costs and expenses. Any excess revenues after costs are covered should be returned to the USF to be used to build infrastructure for other qualified applicants.

(2)When these other entities use the USF funded networks, the rural health care providers for whom this program is targeted should always have the right to recapture the capacity if it is needed in the future, subject to a reasonable notification period of six months to the outside entity.

(3)The outside entity should be charged at the higher of incremental cost or market price for the facilities used. In this case incremental costs would include depreciation, incremental maintenance, incremental labor, and incremental administrative costs incurred. Market price would be the market price for similarly situated rural services, and to incent use of spare capacity, market price may be discounted by 5%. We do not agree with charging at the Fully Distributed Cost level. Including the full proportion of such expenditures, such as including start-up costs, network design costs, contract negotiation costs, etc. would be self-defeating in that it may drive the price up so high it would deter other entities from using the network, resulting in depriving the USF fund recipients of any incremental revenues to help sustain their networks.

(4)Excess capacity should be shared on a first come, first serve basis, in order to maximize the collection of added revenues. Capacity should not be held in reserve for any particular entity. In the event that more outside entities want capacity than is available, priority could be given to state and local government entities.

IV. Health Broadband Service Program

A. Eligible Services

Subsidizing 50% of the eligible health care provider's monthly recurring charges for any advanced telecommunications and information services, regardless of whether they are dedicated or on public networks, is a welcome improvement to the program. We also agree that the subsidy should be technology neutral.

B. Level of Support

We agree that raising the subsidy from 25% to 50% is a good idea. We would go one step further and say that the subsidy level should be equal to the greater of 50% or the mileage/distance sensitive charges. One of the reasons the existing RHC USF funding was underutilized was because many rural health care providers found that the resources involved in caring for the paperwork, the bidding process, and the service changes was disproportionately high for the amount of savings achieved. Most of this paperwork and due diligence is necessary to preserve the integrity of the program, but raising the subsidy level from 25% to 50% will make the savings worth the effort. We also think a simplified approach of using a flat 50% subsidy would be an improvement to the voice telephony services support program as well, and avoid the issues of the blurry line between voice and data services that VoIP technology brings. We do not think that the 50% rule should

be waived for extreme high cost applicants unless there are excess funds remaining in the pool. It is more important to make the funds available to reach larger numbers of rural citizens.

V. Eligible Health Care Providers

Administrative Offices and Data Centers: We applaud the proposal to allow administrative offices and databases that are in separate buildings to be treated as eligible expenses to the extent they are owned or controlled by eligible health care providers. Pursuant to the discussion in paragraph 119 of the NPRM and the related rules in Appendix A, C.F.R. 54.601(b) and (c), we do think it is necessary to clarify that offsite administrative offices or data centers must be at least 51% owned or controlled by either an eligible non-profit or public health care provider *or a consortium made up of at least 51% eligible entities*. The addition of the allowance for consortia would recognize the reality that many small health care providers may prefer to run their telecommunications through a group which can provide expertise and help them realize economies of scale.

VI. Annual Caps and Prioritization Rules

The Commission should leave the door open to re-examine the total $400 million spending cap for the program. If these new rules make the program more popular, as is their goal, at some future date there may be a need for more than $400 million. On the other hand, as schools, libraries, and community colleges become more wired up through the BIP, BTOP, and USF E-rate programs, those needs may decline, freeing up more funds for the rural health care providers just when rural health care providers' needs are ramping up. With this in mind, each year the USAC should forecast the needs for the following year and the

Commission should revisit the $400 million total program cap to determine if $400 million is still the appropriate funding level. Likewise, with new rules aimed at making the program more accessible and worthwhile, the mix of infrastructure program needs vs. broadband program needs may change, and rather than locking in amounts based upon the past underutilized programs, the Commission should once a year reassess how much money would be spent for infrastructure, recurring broadband costs, and voice telephony costs. The allocation should be based on the number of credible applicants' requests the USAC gets each year. It should not be based on what is more administratively workable, for that ignores the main objective of the program, to bring affordable health care to rural America. It is also likely that over time more people will learn how to access the program and comply with its rules and regulations, so long term funding decisions should not be made based upon the Pilot Program's learning curve difficulties.

As far as prioritization rules go, if the demand for money from eligible health care providers exceeds supply, the Commission should not lose sight of the goals of the program, and should find a way to target the funding first to those with the most need. Possibly the F.C.C.'s suggestion to use HPSA scores would be a logical way to prioritize which recipients get money. Absent a concrete suggestion from the NPRM comments, the F.C.C. could consider convening an industry task force to set up prioritization rules. The one caveat is that if a health care provider is about to lose its USF funding due to a forecasted funding shortfall, it should be given a one year warning to avoid rate shock, and to allow it to seek out alternative funding sources or solutions. As stated above, if the USAC is in the position of forecasting a funding shortage in the following year, it should reassess the total program funding allocations.

VIII. Protecting Against Waste, Fraud, and Abuse

Regarding paragraph 140 of the NPRM, the Commission proposes a series of rules to avoid "double dips" by participants. We agree with this approach because in general we think it is best to spread the funds to more health care providers than to concentrate them with a few. We also think these rules are necessary to avoid unjust enrichment.

IX. Data Gathering and Performance Measures

C. Other Performance Measures

With respect to the type of measurements and the frequency of measurements, we urge the Commission to not impose any new burdens on the health care providers. The Commission should use already available medical industry metrics. If too many new administrative requirements are introduced, many health care providers will decide that the costs of this program exceed the benefits, and thus will delay their utilization of the life saving services that broadband can offer.

D. Data Gathering and Analysis

As stated above, administrative requirements on the health care providers should be kept to a minimum so they can concentrate on their core businesses of health care. However, some data should be collected to determine if the broadband program is adding value each year. Therefore, we think it is a good idea to allocate a small portion of the funds for trialing new methods.

Appendix A

Comments on Specific Proposed Rules Changes

54.601 (a) 3, the COMMISSION cross references section 54.5 for the definition of rural area for eligibility purposes. Section 54.5 uses as a cut-off point a Core Based Statistical Area of 25,000 or more in population. If the COMMISSION is concerned about underutilization of the program, it might consider increasing that cutoff level. There are many towns that just miss the cutoff

54.621 (b) In its rewrite of 54.601, it appears the COMMISSION is proposing to eliminate the funding described in 54.621 (b) for toll charge credits. While this subsidy is probably not heavily used, we propose that the COMMISSION should allow a six month warning period before eliminating any funds that are currently being utilized by any healthcare providers.

54.601 (f), (formerly b) on Consortia, the COMMISSION should clarify what it means by the language, "eligible health care providers participating in consortia with ineligible private sector members shall not be eligible for supported services under this subpart. " This seems to conflict with other clauses that allow for prorating of supported services to account for this.

54.601 (b) and (c) on Administrative offices and Data centers respectively, it is possible that large data center and administrative service providers who are specialists will manage broadband and telecommunications functions for eligible health care providers as well as others. There may be many advantages in having large specialists manage these functions, rather than in having health care providers manage them. For example, there may be economies of scale, state of the art equipment and software, and personnel trained in the latest technologies and systems. Without recognizing this and allowing for these costs to receive funding, eligible rural health care providers could be relegated to a "ghetto" of older and more costly data and administrative centers. These paragraphs should be rewritten to allow for a prorated portion of direct expenses of data and administrative centers related to eligible health care provider costs.

54.602 (e) Health Care Purposes, and 54.631 (c) Eligible Services, these paragraphs states that the support must be "reasonably related to the provision of health care services". This should be clarified to add in "…heath care services or health care instruction", since eligible health care educational institutions are covered by this program as well.

54.603 (C) (3), it should be clarified that the 28 day time frame does not apply to the infrastructure program, and paragraph 54.603 (b) should include the timeline specific for the infrastructure program.

54.604 On existing contracts: Many eligible health care providers are in the middle of a service contract when they first become aware of the USF program. They chose to stay away from the program because they do not want to break their existing contracts. An exception should be made in the rules that allows an otherwise eligible health care provider who has not participated in the program before to apply for funds for their existing service on a one-time basis, so that they will not have to choose between violating the sanctity of an existing contract and forgoing the USF funding. This will make it easier for additional health care providers to enter the program. If there is concern about abuse, a cap could be put on the amount of the subsidy under such circumstances.54.605 and 54.609, the Commission should consider simplifying the telecommunications program by utilizing the same 50% support figure it is proposing for the broadband services program, rather than calculating urban versus rural rates.

54.650 – Throughout the section: As noted above, it is more appropriate to leave the building and ownership of infrastructure to carriers or consortiums than to health care providers who have no core strength in this area. If the Commission agrees with this logic, then throughout this section where "health care provider" is noted, it should instead say "health care provider, or carrier or consortium providing infrastructure for the eligible healthcare providers"

54.650 (b) The limitation for accepting applications between July 1 and September 1 should be eliminated and replaced with a statement that accepts applications throughout the year as long as funds remain available. It should also be permissible for carriers and consortiums to submit these applications as long as the service is being provided to health care providers.

54.650 (e) The Commission should change the required build-out period from five years to three years.

54.652 (b) The HCP's agreement to participate during the initial application phase should be allowed to have "escape clauses" in the event the funding is not granted within a reasonable time frame, such as six months, or any portion of the funding is reduced or withdrawn, or other material changes occur.

54.654 (c) Allowable Administrative expenses should to include all of the survey and mapping expenses noted in 54.651, project planning and budget development, writing and posting Requests For Proposals, evaluating supplier proposals, contract work, expenses of hiring and conducting site surveys, and other similar expenses. As such, not allowing administrative expenses until after the participant has been notified that they have been selected for funding is unrealistic, since many of the above legitimate administrative expenses need to occur before the application is finalized. They $100,000 ceiling per year and 10% total are also arbitrary and too low, and should be more in line with the network design ceilings.

54.655 (b) (3) It is not realistic to disallow legal costs, since these projects cannot be done without contracts. These costs, to the extent they are directly related to the project, should be allowed as part of the administrative expense, and the ceiling for administrative expenses should be increased as stated above.

54.655 (b) (14) The word "dedicated" should be removed, since portions of the infrastructure may utilize the public Internet.

54.655 (c) Billing expenses should be allowed, since billing capabilities will enable the long run sustainability of these networks, which is a program requirement.

54.656 (c) and (d) Carriers and fro-profit participants should be allowed to provide funding for these projects. There should be no ineligible sources of funds. With these restrictions it will be very difficult for health care providers to raise funding and apply for these projects, thus negating the purpose of the program. If the Commission is concerned about abuse or excessive profit taking by certain participants, it should restrict how money is to be taken out from the project, not how money is put into the project. The ARRA broadband stimulus projects dealt with these same issues and might serve as a model.

54.659 As stated above, health care providers should not be required to own telecommunications infrastructure (or to lease it). This will only deter most of them from utilizing the program.

54.664 (b) Designation of successor projects. If the Commission sees a need to choose a successor to a project, the selection of the successor should be done through an open bidding process so that any applicant who has the capability to perform gets a fair chance at winning the project.

54.675 (c). See comments on 54.650 (b) above.